The Data Dive, #1 podcast

Cory: Hello and welcome to inaugural episode of the The Data Dive, a series of podcasts discussing the role data play in substance misuse prevention work. My name is Cory Morton and I am an Assistant Professor at the University of New Hampshire's Department of Social Work. The Data Dive is part of the Substance Abuse and Mental Health Services Administration's Prevention Technology Transfer Center Network. I am representing the Northeast and Caribbean Prevention Technology Transfer Center, which serves region two. Our first podcast focuses on the process of prioritizing needs for community prevention work. Our host is Josh Esrick, Senior Policy Analyst at Carnevale Associates. Josh is from the Central East Prevention Technology Transfer Center, serving region three. Hello Josh, where will the Data Dive be taking us today?

Josh: Thanks Cory. I'm here with Kristen Powell, Assistant Research Professor at the Rutgers University School of Social Work and Director of the Northeast and Caribbean Prevention Technology Transfer Center. Kristen is here to talk about her experiences with data prioritization in New Jersey and its importance to the prevention work being done in the state. Data prioritization being a broad term for a number of different techniques used to organize and rank competing needs by various criteria. Kristen, what can you tell us about data prioritization?

Kristen: I think of prioritization within the context of data-driven decisions in the prevention field. Data prioritization is a process that helps us to focus our efforts effectively and efficiently. Many of us feel the pressure of competing needs in our communities. We face multiple challenges as a result of substance misuse. We see trends change overtime and new needs emerge in our communities. Sometimes we need to step back and reassess. What are the most critical needs and how can we focus on those effectively? Data prioritization is critical when local organizations are assessing their communities and trying to determine where to apply their resources. How do we as a local group decide where to focus our efforts to make our communities healthier? I think that the answer comes from using a data prioritization process.

Let's talk about how a community group can carry out a data prioritization process. There are several dimensions we need to consider when prioritizing needs. The first dimension we need to determine is the magnitude of substance misuse issues in our community. How big is the problem here? Perhaps we are looking at the issue of underage drinking in a community. A commonly used data point is the prevalence rate of alcohol use among underage youth. We can use a survey question asking

youth to report any alcohol use in the past 30 days as a measure of prevalence. This could be one measure of many to determine the magnitude of the problem in your community.

The second dimension is the severity of negative outcomes related to the problem. How serious is the nature of outcomes associated with underage drinking here in our community? We need to consider the consequences of underage drinking, such as alcohol involved car crashes or alcohol related injuries among youth.

Thirdly, we want to consider trends over time. Is the problem increasing over time? Is it decreasing? Or do we see that a problem is remaining stable over time? Going back to our example of underage alcohol use, is the prevalence of youth reporting alcohol use in the past 30 days going up, going down, or staying somewhat stable?

A fourth dimension of prioritization is to consider comparisons. For example, we can look at how the problem compares to other geographic areas. We could look at the magnitude at other states or territories or in other counties for comparison. Is this issue better, worse, or the same here as it is in a comparison community?

Once we assess these dimensions individually, we then start to look at the whole picture. Perhaps we see that a problem has been stable in our community across multiple years but remains much higher than a comparison community. For example, prevalence of alcohol use among underage youth in your community has remained the same over the past three years but your comparison community has seen a significant decrease in those same years. If you just looked at magnitude, your group would see the problem has not gotten worse. But once you add the dimension of comparison, you will see where your stable trend fits comparted to a community that has seen improvement. The process of assessing multiple dimensions helps a community make well informed decisions on their highest priorities.

Josh: Fascinating. Thanks Kristen. That's a lot of data you're talking about using there, which I think may be intimidating for some people, so I'd like to turn now to why we should be doing this and making the effort. What can you tell us about the importance of using a data prioritization process?

Kristen: Great point, Josh. When we have limited resources available to address substance misuse and its related consequences, we want to focus efforts on the most important need. To identify what that need really is, and who would benefit the most from prevention services, examining your data and employing a formal prioritization process is key. The end result is a focused list of priorities that you

will target your limited resources to the area where your prevention efforts are most needed.

Additionally, a formal process helps to ensure that we develop a common understanding between the people in the group trying to implement prevention strategies. It also helps us to validate our priorities to our community members and to our stakeholders. Considering all of these reasons, a data prioritization process ensures quality in our end product – which is the resulting priority list. Once we complete this process, we have a map to guide our work to implement strategies that promote healthy lifestyles and reduce the prevalence of substance misuse.

Josh: That makes sense to me. As we know, prevention can involve bringing together a lot of different stakeholders. Any technique for improving the common understanding between everyone involved sounds great me. Getting into the specifics a bit now, what prioritization method did you use for this process and why did you choose it?

Kristen: My recent experience was at both the state level in New Jersey as well as at the community level among coalitions in the state. We used a similar approach at both levels.

We made the prioritization method choice based on guidance from several sources within the prevention science field. First, we used guidance from the Substance Abuse and Mental Health Administration's manual on setting prevention priorities. This guidebook is called "Setting Priorities for Substance Abuse Prevention: Guidance for State Epidemiological Workgroups" and is available online. Additionally, we used the Strategic Prevention Framework, otherwise known as the SPF, as a guiding model for our process. Most states and territories, as well as communities and tribes, use CSAP's Strategic Prevention Framework (SPF) to guide their data-driven prevention work. The SPF aligns well with a data prioritization process.

I will use the state level method as an example since it is fresh in my mind. But this same process can be used at a local level as well. The first step was to convene a formal data workgroup for this process. We needed to be sure we had diverse stakeholders that represented the various components of the prevention system and who had the necessary expertise. This first step was important in fostering collaboration among key stakeholders as we embarked on this process.

The next step was to decide which data elements and criteria we would use in the prioritization process. In New Jersey, like in many states and territories, they are using an outcomes based prevention model so the focus is on consumption patterns and consequences. We decided to look at consumption patterns and consequences related to underage drinking, marijuana misuse, prescription drug misuse, and tobacco use.

The goal was to include multiple data points for consumption patterns and consequences. These data points were at the state-level. The group then decided on the key data dimensions – magnitude, trends across time, and comparison to the US. So we build a database of multiple measures and organized by these categories.
Each data point was tracked for a minimum of three years in order to observe trends across time. Data points were collected for New Jersey as well as for the US, in order to compare New Jersey trends to the US.

Next, we had to decide on a ranking system. We decided to rank data indicators as high, medium, and low priority based on the prevalence of the problem, the trends over time, and how New Jersey compares to the US. We created a decision matrix and color coded high priority in red, medium priority in yellow, and low priority in green. For example, a measure of high priority would be if the problem was increasing over time and was above the comparison rate. An example of a low priority was an indicator that showed a decrease in recent years and showed magnitude as less than the US rate.

Using this matrix of high, medium, and low priority criteria, the group decided on a formula for selecting indicators to include in the final prevention priority list. We decided that all high priority and some medium priority indicators would be included in the final list. The medium priorities required further discussion. For example, a medium priority could be an issue that was stable in New Jersey in the past few years however was higher than the US rates. The data group reviewed all medium priorities and made a decision as a group which to include in the final list. This final list of all high priority and some medium priority needs was used to guide prevention strategies in the state.

Josh: Thanks for sharing that with us. It sounds as though you had access to a lot of data, which is great. For anyone out there at the state-, or especially community-level, I don't want you to be discouraged if you don't have as comprehensive a database. It's fine if your end result looks a bit different from what was done in New Jersey. What's important is following the core principles that Kristen is talking about, and to help with that we've created a companion document that will walk you

through the core steps we are talking about here today. Speaking of which, do you think you could summarize those for us again?

Kristen: Great idea. We can summarize the process into 5 overall steps.

Step 1 – Convene a data workgroup. You need to determine which stakeholders need to be a part of this process and how you will communicate your process and results with other stakeholders.

Step 2 – Determine your method for prioritization. Your data group needs to decide what data and dimensions will be used in your prioritization process. In our example, we used magnitude, trends over time, and comparison to another geographic location. Your group also needs to determine the scoring strategy. In our example, this is where we created a scoring method of high, medium, and low scores.

Step 3 – organize the data in a format that allows the group to apply the dimensions and scoring. This usually is created in some type of worksheet or matrix.

Step 4 –apply the priority setting process to your data. At this point, your data workgroup has determined the indicators, the data sources, the dimensions, and the scoring rules. Now you apply it to all of your data.

Step 5 Now, as a group, you interpret and refine your results. This is where you need to discuss the results and determine if the high priorities make sense and if there is any need to go back and refine the scoring. At this point, the end product is your set of final priorities.

Josh: Thanks for breaking it down like that. Also, you mentioned earlier SAMHSA's manual on setting prevention priorities, and I'd like to remind listeners that SAMHSA and the PTTC Network offer access to numerous resources that could help support others interested in engaging in data prioritization. Any closing thoughts or advice you'd like to give to preventionists who are considering undertaking a similar process?

Kristen:
I think it is important to remember that there might be contextual factors that could impact the prioritization process. While you hope the data driven prioritization process will be fool proof, we must remember subjective factors. For example, once we have our list of high priorities, we then have to think about whether the group has the capacity and resources to address these.

Other factors to consider include how ready your community might be to support your efforts that you are going after. Community readiness to deal with your high priority might not be there yet. If you decide this is the case, that contextual factor would inform your process. Your group might decide to take that priority off the list for now and perhaps address it in the future when readiness is higher.

Josh: Great. Thanks for sharing your thoughts with us today. I found it very informative and I think everyone else will too. Back to you, Cory.

Cory: Thank you, Josh. Companion documents to support data prioritization and a transcript of today's podcast are available for download on our website, pttcnetwork.org. Future episodes of the Data Dive will also be available on the PTTC Network website. Thanks for listening!